Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THE SAN ANTONIO ORTHOPAEDIC GROUP

Respondent Name
SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number
M4-14-1035-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
DECEMBER 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is a copy of the EOB which states 'PREVIOUSLY PAID', "PREVIOUS PAYMENT WS [sic] MADE FOR SERVICE AND A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE". No payment ever recommended or made for these dates of service."

Amount in Dispute: $1,676.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**There may be underlying issues of causal relation**. Attached is a copy of the carrier's dispute information indicating that the condition for which Claimant is being treated is not related to the compensable injury. To the extent that there has been no final resolution of this liability dispute."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2013	CPT Code 20526 Carpal Tunnel Injection	$173.96	$117.25
	CPT Code 20550 Tendon Sheath Injection	$173.96	$89.95
	CPT Code 72040 Cervical X-Ray	$166.02	$55.31
	HCPCS Code J1100 (X3) Injection	$75.00	$0.45
June 25, 2013 July 3, 2013	CPT Code 99080-73 Work Status Report	$22.00 X 2 = $44.00	$30.00
June 25, 2013	CPT Code 97004-59 Occupational Therapy Re-Evaluation	$170.17	$81.93
	CPT Code 97110-59 Therapeutic Procedure	$118.83	$49.54
	CPT Code 97140 Manual Therapy Techniques	$135.38	$46.42
June 28, 2013	CPT Code 97140 (X2) Manual Therapy Techniques	$270.76	$81.74

June 28, 2013	CPT Code 97035 Ultrasound	$67.62	$19.63
June 19, 2013 July 3, 2013	CPT Code 99213 Office Visit	$140.34 X 2 = $280.68	$224.50
TOTAL		$1,676.38	$796.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240, effective July 1, 2012, provides for the processing and audit of health care providers claims by insurance carriers.
3. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
6. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires that in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be fair and reasonable.
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B13-Previously paid. Payment for this claim/service may have been provided a previous payment.
   - 247-A payment or denial has already been recommended for this service.

Issues

1. Does an extent of injury/compensability issue exist in this dispute?
2. What is the reimbursement for the injections, x-rays and office visits?
3. Were the work status reports filed in accordance with 28 Texas Administrative Code §129.5?
4. What is the reimbursement for the physical therapy services?
5. What is the reimbursement for code J1100?

Findings

1. The respondent raises the issue that "**There may be underlying issues of causal relation**" in the position summary.

   28 Texas Administrative Code §133.240(e)(1-2)(C) states "The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:
   (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and
   (2) the injured employee when payment is denied because the health care was: (C) unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements)."

   28 Texas Administrative Code §133.240(h) states "An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:

   (1) the injury is not compensable;
   (2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

   (3) the condition for which the health care was provided was not related to the compensable injury

The Division finds that the extent of injury/compensability issue was not raised on the submitted explanation of benefits. In addition, the respondent did not support that the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 was filed when the insurance carrier reduced or denied payment for the disputed services. The Division concludes that the respondent's position regarding an extent of injury/compensability issue existing for the disputed services is not supported.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.30.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78216, which is located in San Antonio, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Total Allowable Amount	Total Amount Paid	Total Amount Due
20526	$72.14	$117.25	$0.00	$117.25
20550	$55.34	$89.95	$0.00	$89.95
72040	$34.03	$55.31	$0.00	$55.31
99213	$69.06	$112.25 X 2 = $224.50	$0.00	$224.50

3. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:
(1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

The respondent submitted copies of the work status reports dated June 25, 2013 and July 3, 2013 that support billing per 28 Texas Administrative Code §129.5(d)(2); therefore, reimbursement of $15.00 X 2 = $30.00 is recommended.

4. On the disputed dates of service, the requestor also billed for physical therapy services, CPT codes 97004, 97110, 97140, and 97035.

   Medicare's *MLN Matters*, number MM7050, effective January 3, 2011 states "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings."

   Procedure code 97004, service date June 25, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.6 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.6. The practice expense (PE) RVU of 0.94 multiplied by the PE GPCI of 0.912 is 0.85728. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.809 is 0.02427. The sum of 1.48155 is multiplied by the Division conversion factor of $55.30 for a MAR of $81.93. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $81.93.

   Procedure code 97110 represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.912 is 0.43776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.89585 is multiplied by the Division conversion factor of $55.30 for a MAR of $49.54. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $49.54.

   Procedure code 97140 represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.43. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.912 is 0.40128. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.83937 is multiplied by the Division conversion factor of $55.30 for a MAR of $46.42. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.98.

   Procedure code 97140, service date June 28, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.43. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.912 is 0.40128. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.83937 is multiplied by the Division conversion factor of $55.30 for a MAR of $46.42. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $46.42. The PE reduced rate is $35.32. The total is $81.74.

Procedure code 97035 represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.21 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.21. The practice expense (PE) RVU of 0.15 multiplied by the PE GPCI of 0.912 is 0.1368. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.35489 is multiplied by the Division conversion factor of $55.30 for a MAR of $19.63. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $19.63.

5. 28 Texas Administrative Code §134.203 (d)(1) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

   (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS."

   HCPCS code J1100 does not have a fee listed in DMEPOS. Per Texas Medicaid fee schedule code J1100 has an allowable of $0.12. This amount multiplied by 125% equals $0.15. The requestor billed for 3 units; therefore, the DWC total allowable is $0.45.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $796.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $796.72 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/24/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.